When VIP Patients Are Disruptive

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As a psychiatric resident, my knowledge, competence, and confidence are tested frequently. In interactions with VIP patients, tests can be more arduous and public; supervision by hospital administrators and physicians can feel more critical.

On a busy Wednesday evening in the psychiatric emergency department (ED), I was on call and occupied with triaging three patients: a psychotic man; a suicidal woman; and a depressed elderly man. In the midst of this, the crisis worker received a call from a local government official. “There is a wealthy donor on his way in to the hospital; they want us to be prepared.” I rolled my eyes and said, “We have three patients already, the donor will just have to wait his turn.” Within minutes, hospital administrators and the ED staff were running into the psychiatric ED to make sure I had heard of the donor’s impending arrival, telling me to make sure I evaluated him in a “timely” manner, and reminding me of just what the care of this patient could mean to the university hospital.

In anticipation of the patient’s arrival, hospital administrators generated anxiety and an atmosphere of urgency — intentionally, it seemed to me.

A hospital official called to let me know the reason for the donor’s trip to our ED. The patient was an elderly man who had been showing recent signs of paranoia and depression.

Earlier in the day, worried about recent conversations, a local government official had gone to visit him, and the man had threatened to shoot himself. More worrisome was that the man collected antique weapons, and had several guns in the penthouse apartment.

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where he lived. The government official was bringing him to the emergency room for psychiatric evaluation, and, if necessary, involuntary commitment.

Within minutes, the wealthy donor arrived. I was pulled out of an exam room where I was interviewing the suicidal woman, and notified of his arrival. Annoyed, I went back into my patient’s room to finish my exam. Upon my return to the crisis room, an administrator greeted me. “He’s very angry about having to wait so long. You’d better go see him now.”

The donor first had been put in a private waiting room (unlike other ED patients), and within minutes was escorted to an exam room. When I hurried into his exam room, I was greeted by another hospital administrator who was functioning as a sitter and was talking with the patient.

During my interview, the patient complained repeatedly about the wait time, which was less than 20 minutes. He told me that he was hungry, but refused to eat the sandwiches and crackers typically given to other patients. He snapped, “Go get me a steak, and make sure the hospital pays for it!”

He called the hospital CEO, government officials, and high-powered socialites on his cell phone. He referred to the other patients as “peasants” and demanded to be treated differently. After I recommended psychiatric hospitalization, he threatened lawsuits, stated that he would pull his substantial annual donations from the hospital, and informed me that he would tell hospital officials about my “behavior.”

Although the psychiatry attending-on-call and my program director both assured me over the phone that my judgment was “on target,” I felt resentful toward the wealthy donor. I felt bullied by the hospital administration and the patient into hastening the evaluation and making special accommodations, thus delaying the care of other patients.

I left the emergency room that night after admitting the donor to the psychiatric unit on an involuntary basis. I was exhausted, and despite the supportive words of my supervisor, I felt unsure of my work and worried about the consequences of my actions. After the donor was admitted to the psychiatric unit that night, he was transferred the next morning to a medical floor, where he would have a private room and avoid the stigma of being “on the psych ward.” This arrangement had been negotiated by hospital leadership and heads of clinical services.

I was disappointed by this outcome and demoralized that despite my best judgment and efforts, financial concerns and power plays had trumped the values of good patient care. On the medical floor, the patient did not have constant access to the observation and care of the mental health team; and did not receive the same level of care provided to all other psychiatric patients. He had no access to the inpatient therapeutic milieu; and did not receive the evaluation and treatment planning afforded psychiatric inpatients.

Instead, he was seen once daily on rounds by the psychiatric consultation-liaison (CL) team. He was discharged before his family could meet with the psychiatry CL team, and his transition to outpatient psychiatric care was rocky and disrupted, resulting in another ED visit several weeks later.

I felt that the standards of care and ethical guidelines I had been taught to uphold were in conflict with the goals of the hospital administrators. My status as a resident put me at a definite disadvantage in dealing with a prominent patient and negotiating with hospital leadership; I felt threatened and feared the consequences of acting against the patient’s wishes, even as I was trying to advocate for his best medical interest. I imagined the donor no longer making the large donations he had in the past, and my chairman or even the head of the hospital blaming me. I worried that the donor’s phone calls to presidents of organizations and chiefs of departments would have a negative effect on my future career, even my ability to gain employment after training.

While the skills needed to diagnose and recommend treatment for VIP patient may not be significantly different from those needed for other patients, managing the
conflicting pressures generated by the special position, celebrity, and/or power of the VIP — and hospital administration — requires a level of confidence and maturity that can be difficult for a trainee to muster.

Early in training, residents might benefit from a brief introduction to the special clinical and ethical challenges of treating VIPs. When such cases arise, it is important for the supervising attending to realize that the resident may need extra support; the supervising attending psychiatrist may need to speak personally with hospital administration or come in to the ED. Additional support at the level of the program director or even department chair may be called for during the assessment and disposition process.

In my situation, both the attending on call and my program director were explicitly supportive and assured me that the patient must be admitted involuntarily; they would manage any pushback from other sources; and I would graduate from the program on time. These interventions, plus debriefing and later discussions with faculty attendings, helped me process this experience and learn from it.